YUMA REGIONAL MEDICAL CENTER
BARIATRIC SURGERY

Bariatric Surgery Patient History Questionnaire

Your appointment will be delayed if this form is incomplete – please print legibly

Personal Information

Name _____ Date _____

SSN# (for insurance purposes) _____-_____-_____ Date of Birth _____ Age _____

Insurance: _____ ID# _____ Group#_____

Mailing Address _____
_____

City _____ State _____ Zip _____

Daytime Phone _____ Home Phone _____

Cell Phone _____ E-mail Address _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender ☐ Male ☐ Female

Occupation _____ How many hours a week do you work? _____

Number of Children _____ Ages of Children _____ Do you care for elder relatives? _____

Who? _____ What is your involvement in the Care? _____

With whom do you reside? _____

How long have you been contemplating Bariatric surgery? _____

Have you done any research regarding Bariatric surgery? _____

If YES, what type? _____

How did you hear about this program? _____

Do you have a friend or family member who has had Bariatric surgery? _____ Who? _____

Language ☐ English ☐ Spanish

Height	Weight	Ideal body weight	Excess body weight	BMI

PERSONAL MEDICAL HISTORY (Do you have or have you ever had? Check all that apply.)

Cardiovascular Disease	Yes	No	Don't know	Gastrointestinal	Yes	No	Don't know
Heart disease				Colonoscopy date:			
MI (Heart Attack)				Do you experience heartburn or regurgitation?			
Abnormal EKG				How many times per week?			
Have you ever had a stress test?				Medications:			
Have you ever had an echocardiogram?				Urinary			
High blood pressure				Difficulty with urination?			
Do your legs/ankles swell easily?				Frequent bladder infections?			
Do you take medication for the swelling?				Incontinence:			
If so, what medications				Kidney infections?			
Endocrine				Gynecological			
Are you a Diabetic?				Last menstrual period:			
Average Daily Blood Glucose:				Number of pregnancies:			
Medications:				Number of births:			
Do you have thyroid problems?				Last mammogram date:			
Medication:				Was it normal?			
Elevated cholesterol				Last pap smear date:			
Medication:				Was it normal?			
Respiratory				Are you taking hormones (Birth control/HRT)?			
Asthma:				Hematological			
Do you use inhalers?				Do you have a bleeding abnormality?			
Do you take oral medications? If so, what?				If so, describe:			
Shortness of breath				Have you ever had a blood transfusion?			
How far can you walk before you are out of breath?				If so, why?			
Is it getting worse?				AIDS/HIV exposure?			
Sleep Apnea:				Musculoskeletal			
Do you use a C-PAP device?				Back pain			
Psychological				Hip pain			
Depression				Knee pain			
Panic attacks				Ankle/foot pain			
Anxiety				Which of these is worse?			
Bipolar disease				Have you seen an orthopedic doctor for any of the above?			
Obsessive compulsive disease				Is orthopedic surgery pending for any of the above?			
				Other			
				Antibiotic resistant organism?			
				Hepatitis			

Surgeries

Date	Surgery

Hospitalizations

Date	Illness	Treatment

Prescription Medications

Medication	Dose	Frequency

Non-Prescription Medications

Medications	Dose	Frequency

ALLERGIES

Allergic to any medications? ☐ Yes ☐ No

If yes, please list medication and reaction: _____

Surgical tape ☐ Yes ☐ No If yes, please list reaction: _____

Latex ☐ Yes ☐ No If yes, please list reaction: _____

Iodine ☐ Yes ☐ No If yes, please list reaction: _____

DIETING HISTORY

Age you first started dieting: _____ Approximate weight at age 18 _____

Height: _____ Current Weight:_____ Weight range last 5 years _____ to _____

Program	Yes	No	Date(s)	Duration	Max loss	MD supervised?
Jenny Craig						
Nutri-systems						
Weight Watchers						
Opti-fast Medi Fast						
Overeaters Anonymous or TOPS						
Fen/Phen Redux						
Meridia						
Xenical						
Over the counter diet aids						
Atkins Diet						
Other:						
Other:						
Other:						

What was the most successful weight loss you have achieved and how did you do it?

_____

What behaviors did you learn from dieting that you still use today? _ _____

_____

FOOD PREFERENCE

Are you a sweet eater? ☐ Yes ☐ No If so, what? _____

How often? _____

Are you a pasta/bread eater? ☐ Yes ☐ No If so, what? _____

How often?_____

Are you a fast food eater? ☐ Yes ☐ No If so, what? _____

How often? _____

Is snacking from habit? ☐ Yes ☐ No Boredom? ☐ Yes ☐ No Do you binge eat? ☐ Yes ☐ No

How often?_____

What beverages do you consume throughout the day? Quantity? _____

SOCIAL/FAMILY HISTORY

Is there obesity in the family? ☐ Yes ☐ No Who_____

Other medical illness within the family: ☐ Yes ☐ No If yes, what? ☐ Diabetes ☐ Hypertension ☐ Coronary Artery Disease ☐ Other_____

Do you exercise regularly? ☐ Yes ☐ No If yes, what do you do? _____

_____

Do you have any physical restrictions that keep you from exercising? ☐ Yes ☐ No

Explain _____

Have you ever smoked cigarettes/cigars? ☐ Yes ☐ No Do you smoke now? ☐ Yes ☐ No

When did you quit? _____ How much did you smoke per day? _____

Do you drink alcohol? ☐ Yes ☐ No What type of alcohol do you consume? _____

More than 5 drinks per week? ☐ Yes ☐ No Less than 5 drinks per week? ☐ Yes ☐ No

Have you or are you currently using any recreational/illegal drugs? ☐ Yes ☐ No

Explain: _____

Do you have a history of abuse? (Please include emotional, physical, mental, substance or other types of abuse issues you have dealt with. This information is extremely important and very confidential. Honesty is needed in order to provide you with the best possible treatment plan.)

_____

_____

_____

_____

_____

_____

_____

_____

Describe your present life stressors: _____

_____

_____

Describe the present support system you rely upon (church, spouse, family, friends, co-workers, etc)

_____

_____

_____

_____

What is your greatest fear regarding the surgery? _____

_____

_____

_____

_____

_____

_____

What is your greatest hope regarding surgery? _____

_____

_____

_____

_____

_____

_____

Why do you (what is motivating to) seek this type of intervention for weight control?_____

_____

_____

_____

_____

The Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would never doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

Situation	Chance of Dozing
Sitting and reading	
Watching television	
Sitting inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total Score	

SCORE RESULTS:

1-6	Congratulations, you are getting enough sleep!
7-8	Your score is average
9 **and** up	Very sleepy and should seek medical advice

Johns, M.W. (1991). A new method for measuring daytime sleepiness: The Epworth sleepiness scale. Sleep, 14, 540-545. Permission for single-use of the information contained in this material was obtained from the Associated Professional Sleep Societies, LLC, September 2006.

Physicians

Complete information is mandatory, including address, email, phone and fax.

Specialty Name	Address	Phone and Fax Numbers
Primary Care		
GYN		
Orthopedic		
Cardiologist		
Pulmonologist		
Endocrinologist		
Psychologist/ Psychiatrist		
Chiropractor		
Other		

Signature_____ **Date** _____

Please return completed form along with a copy of your insurance card and current authorization (if applicable) to:

Yuma Regional Medical Center
Bariatric Surgery Program
yumalite@yumaregional.org
1501 West 24th Street
Yuma, Arizona 85364
928-336-LITE (5483)